POC Approved 12/12/17

Adrianne L. Saunders

Comparative POC

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445474	A. BUILDING _____ B. WING _____	11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE HEALTH CENTER	1633 HILLVIEW DRIVE ELIZABETHTON, TN 37643

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Long-term Care QIS Comparative Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Centers for Medicare & Medicaid Services (CMS). The facility was found not in substantial compliance with 42 CFR 483 subpart B... Survey Dates: 11/6/17-11/9/17 Survey Census: 60 Sample Size: 25 Supplemental sample: 0	F 000		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 279	1. The Resident Assessment Nurse updated the comprehensive care plan for resident #59 on 11/9/17 to reflect resident's choice to remain in bed, including goals and appropriate interventions necessary to prevent complications related to resident's choice to remain in bed. 2. The Director of Nursing, Assistant Director of Nursing and Resident Assessment Nurses completed review of care plans of all residents that choose to remain in bed on 11/10/17 to ensure that the care plan reflects correct and updated resident care information. No other residents were found to be affected.	12/4/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeannie Boarker

TITLE: Administrator

(X6) DATE: 12/7/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	Continued From page 1 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (*ii*) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to initiate a care plan that included goals and appropriate interventions	F 279	3. The Resident Assessment Nurses were inserviced on 11/10/17 by the Director of Nursing regarding the comprehensive care plan for each resident to include goals and appropriate intervention necessary to prevent complications related to resident's choice to remain in bed. 4. The Director of Nursing and/or Assistant Director of Nursing will audit all completed care plans of residents that remain in bed after their next 2 comprehensive assessments and/or until 100% compliant All results will be reported monthly by the Director of Nursing to the Quality Assurance Performance Improvement Committee comprised of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Pharmacy Consultant, Resident Assessment Nurses, Social Services, Activities Director, Dietary Manager, Environmental Supervisor and Rehab Manager.	

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F 279	Continued From page 2 necessary to prevent complications related the resident's choice to remain in bed. This affected 1 resident (Resident (R) 59) of 12 residents reviewed for care plans. Findings include: A review of R59's record revealed there were diagnoses on the "Face Sheet" that included but were not limited to osteoporosis, difficulty walking, urinary tract infection, muscle weakness and mood disorder. The "Minimum Data Set" (MDS) significant change assessment dated 8/14/17 indicated in Section C that the resident had moderate cognitive impairment. Section G documented R59 required extensive assistance for bed mobility, dressing, toileting and personal hygiene and she was totally dependent for transfers and bathing. Section M documented R59 was at risk for developing a pressure ulcer. The resident was observed in bed during the following dates and times; - 11/6/17 at 9:45 a.m. and 2:30 p.m., - 11/7/17 at 10:00 a.m. and R59 stated she never got out of bed per her choice. Additional observations of R59 in bed at 12:45 p.m. and 2:00 p.m., - 11/8/17 at 9:00 a.m. and 1:00 p.m. An interview with RN1 on 11/9/17 at 10:00 a.m. she verified it was R59's choice never to get out of bed. RN1 verified there was no care plan that addressed the resident's choice to remain in bed. A copy of R59's care plan was requested from the Director of Nursing (DON) on 11/9/17 at 1:00 p.m.	F 279		

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F 279	Continued From page 3 regarding R59's choice to remain in bed. The DON did not produce/provide a care plan. An interview with Registered Nurse (RN)2 on 11/9/17 at 1:15 p.m. revealed R59 had refused to get out of bed. RN2 verified there was no care plan and/or interventions that addressed the resident's refusal to get out of bed. An interview with a Certified Nurse Aide (NA)1 on 11/9/17 at 1:20 p.m. revealed R59 refused to get out of bed. An interview with NA2 on 11/9/17 at 1:25 p.m. verified R59 refused to get out of bed. An interview with NA3 on 11/9/17 at 1:30 p.m. verified R59 refused to get out of bed.	F 279		
F 314 SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers	F 314	1. RN1 was educated by the Director of Nursing on 11/10/17 regarding the "Pressure Ulcer Protocol", including the initial assessment of a pressure ulcer to include the location, stage, size and depth of the pressure ulcer and/or dressing monitored daily and treatment started immediately and not wait until night shift. 2. We acknowledge that all residents at risk for pressure ulcers have the potential to be affected by the alleged deficient practice. 100% audit of residents at risk for pressure ulcers was completed by the Director of Nursing and Assistant Director of Nursing between 11/10/17 – 11/14/17. No other residents were found to be affected	12/4/17

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F 314	Continued From page 4 from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure a pressure ulcer was identified and treated for a resident who was assessed to be at risk for developing pressure ulcers. This affected 1 Resident (R)59 of 5 residents reviewed regarding alterations in skin integrity. Findings include: A review of R59's record revealed there were diagnoses on the "Face Sheet" that included but were not limited to difficulty walking, urinary tract infection, muscle weakness, anemia, mood disorder and atrial fibrillation. The "Minimum Data Set" (MDS) significant change assessment dated 8/14/17 indicated in Section C that the resident had moderate cognitive impairment. Section G documented R59 required extensive assistance for bed mobility, dressing, toileting and personal hygiene and she was totally dependent for transfers and bathing. Section M documented R59 was at risk for developing a pressure ulcer. The "Wound-Weekly Observation Tool" dated 10/9/17 revealed incontinent dermatitis was acquired on 10/9/17. The physician was notified and treatment was initiated. The physician order dated 10/9/17 revealed the sacrum was to be cleansed with wound cleanser, patted dry, calcium alginate applied to the wound bed, skin prep applied to the peri area of the wound. The wound was to be covered every Monday, Wednesday and Friday every shift due to	F 314	3. The Director of Nursing and/or Assistant Director of Nursing educated all licensed staff between 11/10/17 – 12/4/17 on the "Pressure Ulcer protocol" including the initial assessment and when new orders received by physician the treatment to started immediately and not held for night shift. 4. The Director of Nursing and/or Designee will audit treatment orders regarding timely start of treatments by auditing 100% of treatment orders 3 times a week for 4 weeks, then weekly for 2 months and/or until 100% compliant. All residents at risk for pressure ulcers will be assessed by the Director of Nursing and/or Assistant Director of nursing weekly for 4 weeks then monthly until 100% compliant. All results will be reported monthly by the Director of Nursing to the Quality Assurance Performance Improvement Committee comprised of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Pharmacy Consultant, Resident Assessment Nurses, Social Services, Activities Director, Dietary Manager, Environmental Supervisor and Rehab Manager.	

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F 314	Continued From page 5 incontinent dermatitis. The resident was observed in bed during the following dates and times; - 11/6/17 at 9:45 a.m. and 2:30 p.m., - 11/7/17 at 10:00 a.m. and R59 stated she never got out of bed per her choice. Additional observations of R59 in bed at 12:45 p.m. and 2:00 p.m., - 11/8/17 at 9:00 a.m. and 1:00 p.m. An observation and interview made with Registered Nurse (RN) 1 on 11/8/17 at 9:20 a.m. revealed R59's buttocks and perineum were reddened. There was a healing pressure ulcer on the left sacrum observed and there was a broken blister noticed on the left upper posterior thigh. RN1 cleansed the reddened area on the buttocks and perineum. The sacral wound was dried with no dressing. RN1 applied Dermaseptine lotion to the buttocks, perineum and sacral area. RN1 stated the calcium alginate dressing was discontinued this morning (11/8/17). RN1 stated she had completed the treatment to the buttocks, perineum and sacrum. Upon questioning RN1 regarding the broken blister on the left upper posterior thigh, she stated she had not noticed it. A review of the physician orders dated 11/9/17 revealed the following new orders, calcium alginate dressing was discontinued, Zinc oxide was ordered to be applied to the sacral wound twice a day and Dermaseptine was to be applied to the incontinence dermatitis twice a day. An interview with RN1 on 11/9/17 at 10:20 a.m. verified the treatment to the incontinent dermatitis and the sacral wound were changed at 6:13 a.m. on 11/9/17. She verified she did not apply the	F 314		

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F 314	Continued From page 6	F 314		

Zinc Oxide to the sacral wound, as ordered. She stated when a new treatment was ordered regardless of the time of day, the treatment was not started until the night shift. RN1 also verified she did not notice the broken blister until surveyor intervention. She verified the blister was from pressure and further acknowledged she did not measure the blister or document a description of it.

An interview with the Assistant Director of Nursing (ADON) on 11/9/17 at 11:10 a.m. verified there was no policy that indicated treatments were not to be started until the night shift even when they were ordered in the morning.

A review of the "Pressure Ulcer Protocol," undated, revealed there was nothing noted in the policy regarding starting treatments on the night shift. The protocol documented that the initial assessment of a pressure ulcer should include the location, stage, size and depth and the pressure ulcer and/or dressing should be monitored daily. The evaluation of the pressure ulcer should include location and staging, size, any drainage, a description of the wound bed and a description of the surrounding area.